GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

STATE HEALTH BENEFIT PLAN (SHBP)
TOBACCO CESSATION AFFIDAVIT FORM

Policyholder/Plan Member Name_____

Social Security Number_____

Health Plan Option: (check one) **CIGNA OAP, CIGNA HDHP, CIGNA HMO, CIGNA HRA, UHC OAP, UHC HDHP, UHC HMO, UHC HRA**

☐ I hereby certify that all covered members have not used any tobacco products within the last 60 days. In addition, I have attached a certificate of attendance affirming that each dependent that previously used tobacco has completed all classes in a SHBP approved tobacco cessation program

☐ I understand that as a SHBP member I have the responsibility to read the current Decision Guide and the Summary Plan Description (SPD) of my chosen health benefit option

☐ I understand it is my responsibility to access the open enrollment Web site each year to make elections and answer the surcharge questions to prevent default surcharges

☐ I also understand that this document must be completed, all boxes checked and returned to my payroll location benefit coordinator in order to remove the tobacco surcharge currently being applied to my health coverage premium. In addition, if I or any covered dependents resume using any tobacco products after attending these classes, I will complete the necessary document to notify the Plan. No refund in premiums will be made for any previous deductions that included the surcharge amounts. Section 125 rules for Cafeteria Plans require all changes in premium are prospective.

I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1,000 or imprisonment for not less than one and no more than five years, or both, and I may lose health coverage for one year, if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health (DCH) regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature_____ **Date** _____

Note: Once you have read and signed this affidavit you must submit it to your payroll location benefit coordinator to have the required deduction information completed. If this form is received without a signature, all boxes checked and the tobacco cessation attendance certificate, it will be returned to your payroll location and will delay processing.

Department/School System Use Only		
Payroll Location #	**Date of first deduction**	**Deduction Amount**

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